Health Services
LOS ANGELES COUNTY

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November 16, 2010

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF PHYSICIAN SERVICES FOR INDIGENTS PROGRAM AGREEMENT
(ALL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval of the revised emergency physician services participation Agreement under the Physician Services for Indigents Program and delegate authority to establish future reimbursement rates based on projected revenue and expenditures.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Authorize the Interim Director of Health Services (Interim Director), or his designee, to offer a revised emergency physician services Agreement, for the period July 1, 2010 through June 30, 2013, to eligible physicians providing emergency services at non-County hospitals under the Physician Services for Indigents Program (PSIP).

2. Delegate authority to the Interim Director, or his designee, to establish the PSIP reimbursement rate for future fiscal years, beginning with FY 2011-12, based on projected revenue and expenditures, upon approval by County Counsel, with notification to your Board and the Chief Executive Office.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

The Department of Health Services (DHS) currently administers the PSIP, and physicians enrolled in the program by completing an enrollment package that includes a participation agreement. Physician reimbursement rates are adjusted periodically based on available funding.

On February 16, 2010, your Board instructed the Auditor-Controller (A-C), in consultation with affected department heads, County Counsel, the Emergency Medical Services (EMS) Commission, the County's Hospitals and Health Care Delivery Commission, and the Physician Reimbursement Advisory Committee, to conduct a policy and operational review of the DHS PSIP. Although the A-C has not finalized their report, they have discussed their recommendations with DHS. The A-C recommended revisions to the existing physician participation agreement. In addition, the A-C recommended that your Board delegate authority to DHS to approve changes to the physician reimbursement rates. Therefore, those recommendations are included below.

Approval of the first recommendation will enable the Interim Director to offer a revised emergency physician services agreement, Exhibit I, to eligible physicians. The PSIP enrollment period is currently for a one-year period and the revised agreement provides for a three-year period which will help facilitate physician claim submission and mitigate payment delays. The reimbursement rate for PSIP will remain at 18 percent of the Official County Fee Schedule for FY 2010-11.

The revised Agreement also adds provisions requiring physicians to bill patients a reduced settlement amount before submitting PSIP claims, beginning in FY 2010-11. This will ensure that physicians have made additional attempts to collect from the patients prior to submitting claims to the County. Under the previous agreement, DHS took a sampling of claims, determined an error rate based on the aggregate billed amount, and then applied that rate to all claims submitted by the provider to determine the amount owed to DHS. The revised agreement provides that DHS take a sampling of claims and if an erroneous amount is billed, the provider is required to pay that amount back to DHS with an added 50 percent assessment.

Approval of the second recommendation will allow the DHS to expeditiously implement the future fiscal years' reimbursement rate for non-county physician emergency services claims. DHS establishes the PSIP reimbursement rate by comparing estimated annual funding to estimated total payments at different potential rates. While Measure B and South LA Preservation Funds are the same each year, SB 612/SB1773 funds vary annually. DHS estimates annual SB 612/SB1773 funding by reviewing monthly collection information from prior periods and evaluating various forecasting methods (e.g., average monthly collections, etc.). A-C reviewed actual collections during FY 2009-10 and noted that DHS' estimates were generally accurate. DHS will exercise its delegated authority to establish future rates paid to providers under the PSIP using a similar method.

In addition to notifying your Board of a reimbursement rate change, DHS will notify providers of the impending change and post the issue for public comments at a meeting of the EMS Commission prior to implementing any changes.

Implementation of Strategic Plan Goals

The recommended actions support Goal 1, Operational Effectiveness, and Goal 4, Health and Mental Health, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

The estimated cost of PSIP services provided for FY 2010-11 is $18.4 million, funded by SB 612 (Maddy), SB 1773, Measure B, and the South LA Preservation Fund revenues. Funding for PSIP is included in the DHS FY 2010-11 Final Budget and will be requested in future fiscal years.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Pursuant to the authority granted under California Health and Safety (H&S) Code Section 1797.98a.(b)(1) the County established an emergency medical services fund to pay for emergency medical services, including but not limited to, reimbursements to physicians, surgeons, and hospitals for indigent patients treated in non-County hospitals.

H&S Code Section 1797.98e.(a) requires an agency administering emergency medical services funds to fairly prorate, without preference, payments to each claimant at a level less than the maximum payment level, when the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, would exceed the total amount of funds available for payment.

Based on the State's elimination of the Emergency Medical Services Appropriation in FY 2009-10, on February 16, 2010 your Board approved DHS' request to reduce the initial reimbursement rate for non-County physician services claims from 27 percent to 18 percent effective July 1, 2009. The reimbursement rate will remain at 18 percent for FY 2010-11.

Any non-County physician providing emergency services to indigent patients at non-County hospitals is eligible to participate in the PSIP by completing the July 1, 2010 to June 30, 2013 Conditions of Participation Agreement and the Program Enrollment Provider Form.

Currently there are over 4,000 physicians enrolled in the PSIP. It is estimated that in FY 2010-11 the number of claims to be paid will increase to over 400,000.

County Counsel has reviewed and approved Exhibit I as to use and form.

CONTRACTING PROCESS

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of this request will enable payment of all submitted claims for FY 2010-11 under the PSIP.

Respectfully submitted,

JOHN F. SCHUNHOFF, Ph.D.
Interim Director

JFS:rg

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

EXHIBIT I

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS INDIGENT SERVICES PROGRAMS

JULY 1, 2010 TO JUNE 30, 2013
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
P.O. BOX 2340
BASSETT, CALIFORNIA 91746-0340

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for services provided by him/her to patients who do not have health insurance coverage for medical services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government. Programs covered by this single agreement include:

Physician Services for Indigents Program -- Emergency services (at hospitals defined in the Billing Procedures) for up to 72 hours (except for eligible trauma patients under other programs below).
Trauma Services for Indigents Program -- Trauma services provided in an acute setting for full length of stay at a Los Angeles County designated trauma center.
Impacted Hospital Program -- Emergency services and/or inpatient services provided for up to six inpatient days at a Los Angeles County designated Impacted Hospitals (associated with closure of MLK-Harbor Hospital).
Physicians Services for Indigents Program-MetroCare -- Inpatient services for patients transferred from a County-operated or Impacted Hospitals (see above) to St. Vincent Medical Center.

Physician acknowledges receipt of a copy of the applicable Billing Procedures for each program (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, the terms and conditions of which are incorporated herein by reference.

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under any of these programs. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under any of these programs. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Procedures, including, but not limited to, (1) availability of monies, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

TYPED/PRINTED NAME OF PHYSICIAN	TAX ID NUMBER
PRIMARY SPECIALTY OF PHYSICIAN	SIGNATURE OF PHYSICIAN
STATE LICENSE NUMBER	DATE

COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

BILLING PROCEDURES

JULY 1, 2010 TO JUNE 30, 2013

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions Code ("WIC"), Sections 16950, et seq., and Health and Safety Code ("HSC"), Sections 1797.98a, et seq., a Physician Services for Indigents Program ("PSIP") has been established by the County of Los Angeles ("County") to provide reimbursement to private physicians ("Physician") for certain professional services that have been rendered in Los Angeles County to eligible indigent patients. Professional physician services herein referred to are limited to emergency services as defined in WIC, Section 16953; obstetric services as defined in WIC, Section 16905.5; and pediatric services as defined in WIC, Section 16907.5.

Professional physician services which can be reimbursed under this claiming process are additionally restricted as prescribed by the County, with such restrictions subject to revision from time to time. Current County physician reimbursement restrictions are set forth in "Department of Health Services Physician Reimbursement Policies, attached as Exhibit "A" hereto and incorporated herein by reference. The County has discretion to revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

In no event may this claiming process be used by Physician if his/her services are included in whole or in part in hospital or physician services claimed by a hospital or by Physician under a separate formal contract with County. Nor may this claiming process be used if Physician has previously billed County for his/her emergency, obstetric, or pediatric services under any other claiming process established by County.

This document defines the procedures which must be followed by Physician in seeking reimbursement under this Program. Submission of a claim by Physician under these procedures establishes (1) a contractual relationship between the County and Physician covering the services provided and (2) signifies Physician's acceptance of all terms and conditions herein.

These claiming procedures are effective immediately; are only valid for covered services to the extent that monies are available therefor; and are subject to revisions as required by State laws and regulations and County requirements. This claiming process may not be used by a physician if he or she is an employee of a County hospital.

II. PHYSICIAN ELIGIBILITY

A. Physician must complete a Physician Services for Indigents Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 5). Physician claims will not be accepted if said Agreement is not on file.

B. Physicians who provide emergency services to eligible patients in a Los Angeles County (1) basic or comprehensive emergency department of a licensed general acute care hospital, (2) standby emergency department that was in existence on January 1, 1989 in a small and rural hospital as defined in HSC, Section 124840, or (3) site approved by the County prior to January 1, 1990, as a paramedic receiving station for the treatment of patients with emergency medical conditions, may submit claims hereunder, if all the following conditions are met:

1. Emergency services are provided in person, on site, and in an eligible service setting.

2. Emergency services are provided on the calendar day on which emergency services are first provided, and on the immediately following two calendar days.

Notwithstanding paragraph II B 2 above, if it is necessary to transfer the patient to a second facility that provides for a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided to the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

Physician employees of a County hospital are not, however, eligible for reimbursement under this claiming process.

C. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

D. Physicians who provide medically necessary obstetric or pediatric services to an eligible patient in a hospital, emergency department, or private office located in Los Angeles County, other than a hospital, emergency department, or office owned or operated by the County, may submit a claim hereunder. However, no physician may submit a claim for services provided in a primary care clinic which receives funding under provisions of Chapter 1331, Statutes of 1989.

E. An emergency physician and surgeon or an emergency physician group with a gross billings arrangement with a hospital located in Los Angeles County shall be entitled to receive reimbursement for services provided in that hospital, if all of the following conditions are met:

1. The services are provided in a basic or comprehensive general acute care hospital emergency department.

2. The physician and surgeon is not an employee of the hospital.

3. All provisions of Section III of these Billing Procedures are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

4. Reimbursement is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon or an emergency physician group.

For the purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays a percentage of the emergency physician and surgeon's or group's billings for all patients.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Patients covered by this claiming process are only those who do not have health insurance coverage for emergency services and care, cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, but with the exception of claims submitted for reimbursement through Section 1011 of the Federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

During the time prior to submission of the bill to the County, Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claiming process, reimbursement for unpaid physician billings shall be limited to the following:

(a) patients for whom Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and

(c) either of the following has occurred:

1. A period of not less than three (3) months has passed from the date Physician billed the patient or responsible third party, during which time Physician has made reasonable efforts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. Physician has attempted to settle by offering to bill patients a reduced amount, i.e., a percentage of total charges.

3. Physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses. If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles/Department of Health Services

Refund checks should be accompanied by:
-- a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Special Funds Unit
313 North Figueroa Street, Room 531
Los Angeles, CA 90012

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided. All claims for services provided during a fiscal year (July 1 through June 30) must be received by County's Claim Adjudicator no later than October 31st of the following fiscal year. Claims received after this deadline has passed will not be paid.

VI. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be limited to a maximum of 34% of the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS, which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value.

The payment rate for Fiscal Year 2010-11 is 18%. Future rates will be approved by the County Department of Health Services based on projected revenues and expenditures.

VII. COMPLETION OF FORMS

A. Complete "Conditions of Participation Agreement" for the Physician Services for Indigents Program (sample attached as Exhibit "D"). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

B. Complete one HFCA-1500 Form per patient.

C. Complete one Physician Services for Indigents Program (PSIP) Demographic Data Form (previously CHIP Form) per patient (sample attached as Exhibit "D"). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the Instructions for Submission of Claims and Data Collection (attached as Exhibit "C").

VIII. ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (800) 303-5242.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: PSIP

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter; however, in no case shall claims be resubmitted later than the last working day of June of the following fiscal year.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All resubmissions or appeals must be received by Claims Adjudicator within twelve (12) months after the close of the fiscal year during which services were provided, no later than the last working day of June of the following fiscal year. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - (800) 303-5242

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors (Board). To the extent such monies are available for expenditure under the Physician Services for Indigents Program, and until such available monies are exhausted, valid claims may be paid. Valid claims will be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the PSIP. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

Audited claims that do not comply with program requirements shall result in a refund to the County of the claim amount plus a penalty of fifty percent (50%) of the amount paid for each claim. Audit results may be appealed to the EMS Agency Director, or his/her designee.

If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement hereunder, Physician shall, upon receipt of County audit refunding therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.